ADDRESSING THE INVERSE CARE LAW IN SCOTLAND

The availability of good medical care tends to vary inversely with the need for it in the population served.

Julian Tudor Hart, Lancet 1971

The inverse care law in Scotland is a policy which constrains good medical care in deprived areas, resulting in under-achievement by the NHS in mitigating the effects of poor health and addressing the longstanding nature of health inequalities.

This figure, from The Shape of Primary Care (Glasgow Centre for Population Health, 2008), encapsulates the inverse care law as it currently operates in Greater Glasgow and Clyde (but a similar figure could be produced for Scotland as a whole).

While three separate measures of ill health (Yellow – self-reported health under 65, reported in the Census; Blue – standardised mortality ratio under 75; Blue – long term limiting illness under 65, reported in the Census), increase by 2.5-3 fold between the most affluent and most deprived tenths of the population (from left to right in the figure), the distribution of general practitioners (Black line) is virtually flat.
The figure explains why, in a study of 3000 general practice consultations in the West of Scotland (Mercer & Watt, Annals of Family Medicine 2007;5:503-10), consultations in deprived areas were characterised by:

- More multimorbidity and social problems
- Less time
- Less patient enablement (especially for patients with mental health problems, which is the commonest co-morbidity)
- Increased practitioner stress

When there is insufficient time to address patients’ problems, needs go unmet and do not result in health care activity. When health care activity is used as a proxy measure of need, unmet needs are missing from the data, helping to explain the serial failure of the Arbuthnott Report Fair Shares for All, and the work of the NRAC, to address the inverse care law in Scotland.

Most causes of poor health and health inequalities operate outside the health service, but the NHS can exacerbate them if care is delivered inequitably, on the basis of need.

Tudor Hart identified three principal explanations of the inverse care law:

1. The effect of markets on health care, failing to provide for the majority what they provide for the few
2. The lack of resources in deprived areas
3. The ability of some social groups to make better use of the NHS than others

The second and third explanations still operate in Scotland.

Universal coverage is essential but does not in itself ensure that needs are met. In practice, the task of assessing needs and delivering care proportionately falls to front line practitioners. In hospital this is generally achieved, but in primary care general practitioners are constrained by lack of time.

On 10th April 2013, the report of the Public Audit Committee on Health Inequalities to the Scottish parliament recommended, The Health and Sport Committee may wish to pursue the possibility of the Scottish Government overcoming the practical barriers to collating WTE headcount figures for GPs, and providing this information broken down according to level of deprivation.*

This recommendation appears to have fallen at the first hurdle. The most recent ISD Workforce Survey in 2013 (in a 68% sample of Scottish practices – 41% in Greater Glasgow) estimated GP WTE input at 7.3 per 10,000 patients for Scotland as a whole, 6.8 in Greater Glasgow (where 84 of the 100 most deprived practice populations are based), 6.0 in Lanarkshire, compared with 7.3 in Grampian, 7.4 in Lothian, 7.6 in Tayside and 10.6 in Highland, but there was no attempt to analyse these data “according to level of deprivation.”
This briefing paper addresses the issue of GP manpower but the whole primary care team is under pressure in very deprived areas. Similar scrutiny should be applied to the distribution and workloads of health visitors, community midwives, district nurses and others.

Addressing the inverse care law is not an end in itself, but an essential first step in ensuring the equitable delivery of integrated care, as the NHS gears up help people live better and longer lives with multimorbidity (1). If such care is not delivered equitably, inequalities in health will widen.

Until 2009, General Practitioners at the Deep End, working in the 100 most deprived communities in Scotland, had never been convened or consulted by anyone. For 5 years the group has campaigned to draw attention to the gross circumstances under which NHS primary care services are provided in the areas of greatest need.

The solution to the inverse care law is not simply an increase in the number of general practitioners, although additional clinical capacity is needed to relieve the pressure on existing staff and to enable new developments in care. We propose an extra GP session per week per 1000 patients with addresses in the 15% most deprived datazones – about a 7% increase (1). Improvements are also needed in the links between practices and other services, between primary and secondary care, and with community resources.

The first step by the Scottish Government, however, should be a commitment to the principle that universal coverage is accompanied by measures to ensure that care can be delivered proportionately on the basis of need. The Government should then ensure that the principle is upheld.

Professor Graham Watt
General Practitioners at the Deep End
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Reference
   http://www.gla.ac.uk/media/media_271030_en.pdf